

Case Number:	CM14-0029316		
Date Assigned:	06/20/2014	Date of Injury:	03/27/2013
Decision Date:	07/17/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/07/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 37-year-old male who reported an injury on 03/27/2013. The mechanism of injury reportedly occurred while pushing a heavy box. The diagnoses included status post right shoulder arthroscopy on 01/31/2014. Per the 02/06/2014 progress report, the injured worker reported right shoulder pain rated 8/10. The injured worker reported wearing his postsurgical sling and limited improvement with the use of hot/cold therapy. Current medications included hydrocodone 5/325 mg. The injured worker reported he did not find the medication helpful. Examination of the shoulder noted a visible scar and nonspecific tenderness to palpation. Prior therapies included physical therapy. The treatment plan included hydrocodone 10/325 mg, the Request for Authorization form for a postoperative cold therapy system, deep venous thrombosis prevention system, programmable pain pump, and sling was submitted on 01/28/2014. The cold therapy unit was requested to reduce pain and swelling. The provider noted the deep venous thrombosis prevention system would use cold therapy to combat pain and swelling. The pain pump was requested to minimize the pain associated with surgery and decrease the injured worker's consumption of prescription pain pills. The sling was requested to stabilize and to protect the joint.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retrospective request for one pro-sling with abductor pillow between 1/31/14 and 1/31/14.:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the brief use of a sling for severe shoulder pain to prevent stiffness in cases of rotator cuff conditions. The Official Disability Guidelines further state that the use of a postoperative abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The medical records provided indicate the injured worker underwent a right shoulder arthroscopy on 01/31/2014. The guidelines do not support the use of a postoperative abduction pillow sling for arthroscopic repairs. Therefore, the request for one pro-sling with abductor pillow (DOS: 1/31/14) is not medically necessary.

Retrospective request for twenty-one days rental of Deep Vein Thrombosis Prevention System between 1/31/14 and 1/31/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Venous thrombosis.

Decision rationale: The Official Disability Guidelines recommend monitoring the risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods. The incidence of upper extremity deep vein thrombosis is much less than that of the lower extremities. It is recommended to treat patients of asymptomatic mild upper extremity deep vein thrombosis with anticoagulation alone and patients of severe or extensive upper extremity deep vein thrombosis with motorized mechanical devices in conjunction with pharmacological thrombolysis. The provider's rationale for the request stated the prevention system would use cold therapy to combat pain and swelling. The medical records provided do not indicate the injured worker was at risk of severe upper extremity deep vein thrombosis to warrant the use of a prevention system. The medical necessity of a deep vein thrombosis prevention system was not established. Therefore, the request for twenty-one days rental of Deep Vein Thrombosis Prevention System (DOS: 1/31/14) is not medically necessary.

Retrospective request for twenty-one day rental for Cold Therapy Unit with Wrap between 1/31/14 and 1/31/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous-flow cryotherapy.

Decision rationale: The Official Disability Guidelines state the use of continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The medical records provided indicate the injured worker underwent a right shoulder arthroscopy on 1/31/2014. The request for a 21-day rental exceeds the guideline recommendations of up to 7 days of use. Therefore, the request for twenty-one day rental for Cold Therapy Unit with Wrap (DOS: 1/31/14) is not medically necessary.

Retrospective request for purchase of one programmable pain pump between 1/31/14 and 1/31/14.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Online Edition, Shoulder Chapter-Postoperative pain pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Postoperative pain pump.

Decision rationale: The Official Disability Guidelines state the use of a postoperative pain pump for the shoulder is not recommended. There is insufficient evidence to conclude that direct infusion is more effective than conventional pre- or postoperative pain control using oral, intramuscular, or intravenous measures. The use of a postoperative pain pump for the shoulder is not supported by the guidelines. The request for purchase of one programmable pain pump (DOS: 1/31/14) is not medically necessary.